

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-033549

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 286
FILED SEP 17 1962

VS 300
Rev. 4/59

10017

20010

3

4 0

5 0

6

7 0

8 2

9241X

10

11

12 2-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirkseville</u>		c. CITY OR TOWN <u>Novinger</u>	
Length of stay in 1b <u>Minutes</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kirksville Osteopathic</u>		d. STREET ADDRESS (If outside, give location) <u>RFD</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Delimus Wallace</u>		4. DATE OF DEATH Month Day Year <u>September 11, 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1909</u>
9. AGE (last birthday) <u>52</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (City and state or country) <u>Adair Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W.R. Wallace</u>		13b. MOTHER'S MAIDEN NAME <u>Maggie Troup</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		17. INFORMANT Address <u>George Wallace Novinger, Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>years</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cor pulmonale</u> <u>Asthma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>Sept 3, 1962</u> to <u>Sept 11, 1962</u> and last saw him alive on <u>Sept 10, 1962</u> . Death occurred at <u>6:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. T. Lutenach</u>		22b. ADDRESS <u>Kirksville Mo</u>	
22c. DATE SIGNED <u>9-12-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>9-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pratt</u>		23d. LOCATION (City, town, or county) <u>Adair Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Des Miley Funeral Home, Inc.</u> 415 North Franklin Kirkville, Missouri		25. DATE RECD. BY LOCAL REG. <u>Sept 13 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Marion W. Rathoff</u>		(Licensed Embalmer's Statement on Reverse Side)	

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued Sept 13, 1962

M.T. GUTENSOHN, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Larry Jackson

Licensed Embalmer No. 5158

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.